added to the base rate.

c. To calculate the reimbursement for a per case DRG claim, the rate determined above is multiplied by the relative weight for that DRG. Outlier amounts will be added if applicable.

2. Per Diem Prospective Payment Rates

The following steps are involved in the computation of per diem reimbursement rates.

a. Each facility's cost allocated to the per diem DRGs is divided by the facility's per diem days to compute a hospital-specific cost per day. This cost per day is multiplied by each of the statewide category relative weights to compute a per diem rate for each category. The 6 categories and their weights are listed below.

	Non-Surgery	Surgery
° Routine	.60780	.84015
° Special Care	2.03225	2.58841
° NICU	1.25595	1.54758

Hospitals not providing special care or neonatal intensive care will not be assigned rates in these categories. For the purpose of these categories, minor surgeries are excluded from the surgery category.

b. Hospital-specific add-ons are added to the base rate as was the case in Section V A. However, Medicaid per diem days are substituted in each computation for discharges.

c. To calculate reimbursement for a per diem DRG claim, the appropriate per diem rate is multiplied by the number of days in the stay. Once the length of stay reaches the threshold (200% of the hospital's average for the category), the payment is reduced to 60% of the per diem. The threshold is equal to 200% of the ALOS for the highest level of care.

d. For hospitals with an insufficient number of days in a per diem category to develop a statistically reliable average cost per day, the statewide average rate will be used.

3. Per Diem Prospective Payment Rate - Long-Term Psychiatric Facilities

Only freestanding long-term care psychiatric facilities are included in this computation.

a. Adjusted Medicaid inpatient room and board costs are summed across all participating freestanding long-term care psychiatric facilities. The number of days of care are summed across these facilities and the result is divided into the total adjusted costs to yield the statewide average per diem.

b. Hospital specific factors are added to the base rate as was the case in Section V A. Medicaid days for freestanding long-term care psychiatric facilities are substituted in each computation for discharges. For freestanding long-term care psychiatric facilities providing ancillary services, an ancillary add-on is added to the base rate. The ancillary add-on is calculated in the same manner as the capital, DME and IME add-ons.

c. To determine the amount of reimbursement for a particular claim, the number of certified days of stay is multiplied by the per diem rate for long-term care psychiatric services. No outlier payments will be made for reimbursement to long-term care psychiatric facilities.

B. Psychiatric Residential Treatment Facility

A per diem rate will be calculated for each South Carolina contracting psychiatric RTF. The rate will be calculated using allowable 1997 base year cost and statistical data trended forward to January 1, 2000. The rate will cover all costs included in the "all inclusive" rate definition. An occupancy adjustment will be applied if the base year occupancy rate is less than the statewide average occupancy rate. If applicable, add-ons may be applied to the RTF rate for services required by the RTF program subsequent to the 1997 cost reporting period. State-owned and operated facilities, public facilities and new facilities will receive special consideration as specified below.

1. Facility Rate (excluding state-owned and operated, public and new facilities)

The per diem reimbursement rate will be calculated by dividing total allowable cost by the greater of actual bed days or 84% of total available bed days. This rate will be trended forward to January 1, 2000. If applicable, add-ons may be applied to the RTF rate for services required by the RTF program subsequent to the 1997 cost reporting period. These add-ons will be subject to an occupancy adjustment, if applicable, and will be trended forward from the period the cost was incurred to January 1, 2000.

2. State-Owned and Operated Facility Rate

The per diem reimbursement rate will be calculated by dividing total allowable cost by actual bed days. No occupancy adjustment will be made.

3. Public Facility Rate

The statewide average RTF rate will be paid to public RTFs.

4. New Facility Rate

RTFs enrolled in the SCDHHS Medicaid program subsequent to the 1997 base year, will be reimbursed the statewide average RTF rate.

VI. Special Payment Provisions

A. Payment for Outlier Cases - Per Discharge DRG Cases Only

1. Payments in addition to the base DRG reimbursement are available to a facility for covered inpatient services provided to a Medicaid recipient if the following conditions are met:

   a. The recipient's covered length of stay exceeds the day outlier threshold for the applicable DRG. The day outlier threshold is three standard deviations above the statewide geometric mean length of stay.

   b. The hospital's adjusted cost for a claim exceeds $10,000 and the cost outlier threshold. The hospital's adjusted cost is derived by applying the statewide cost-to-charge ratio to the hospital's allowable claim charges. The threshold is calculated by computing two standard deviations above the statewide geometric mean charge, multiplied by the statewide cost-to-charge ratio.

   c. If a claim meets the conditions of 1a and 1b above it will be reimbursed the greater of the two outlier amounts.

2. Additional payments for cases meeting conditions described in 1a above (day outliers) shall be made as follows:

   a. If the hospital discharge includes covered days of care beyond the day outlier threshold for the applicable DRG, an additional payment will be made to the provider for those days. A special request by the hospital is not required in order to initiate this payment.

   b. A sample review of day outlier cases will be conducted by the state or its designated review organization. Review will focus on those areas defined in Section IX A.

   c. Any days in the stay identified by the state or its review organization as noncovered days will reduce the number of days reimbursed at the day outlier rate, not to exceed the number of days which occur after the day outlier threshold established under 1a above.

   d. Additional payment for day outliers will be 60% of the average per diem payment for the applicable DRG, which will be calculated by dividing the hospital's payment rate for the applicable DRG by the statewide geometric mean length of stay for that DRG, and then multiplying that quotient by 0.60. The day outlier payment will then be determined by multiplying the number of covered days beyond the day threshold times the calculated per diem amount. The hospital's total payment for the case will be the PPS rate specified in Section V of this plan plus the outlier payment.

3. Additional payments for cases meeting the conditions in 1b above (cost outliers) will be made as follows:

   a. If the hospital discharge includes cost beyond the cost outlier threshold for the applicable DRG, an additional payment will be made to the provider for those costs. A special request by the hospital is not required in order to initiate this payment.

   b. Charges for any services identified through utilization review as noncovered services, will be denied and any outlier payment made for these services will be recovered.

   c. The additional payment amount for cost outliers shall be derived by multiplying 75% of the difference between the hospital's adjusted cost for the discharge and the threshold described in 1 b of this section. The hospital's total payment for the case will be the DRG rate specified in Section V plus the outlier payment as described in this section.

B. Reduced Payment for Long Per Diem Stays

In cases where the length of stay for a per diem DRG exceeds 200% of the applicable hospital-specific average length of stay, the days over this threshold shall be paid 60% of the full per diem. Only one threshold, based on the highest level of care, is calculated. The order of precedence will be neonatal, intensive care/special care, and then routine.

C. Payment for Transfers

1. Special payment provisions will apply when a patient has been transferred from one hospital to another.

   a. A hospital inpatient will be considered "transferred" when the patient has been moved from one acute inpatient facility to another acute inpatient facility. Movement of a patient from one unit to another unit within the same hospital will not constitute a transfer.

   b. A hospital which received a transfer and subsequently discharges that individual will be considered the discharging hospital. All other hospitals which admitted the subsequently transferred patient during a single spell of illness will be considered transferring hospitals. The discharging hospital's principal diagnosis will determine the nature of the case as a per diem or a per discharge payment to the transferring hospital, except in the case of DRGs 385 and 456.

2. Payment to a freestanding long-term care psychiatric facility which transfers or discharges a patient will be based on its per diem payment in accordance with Section V.

3. Payment to a general hospital for a transfer claim under the DRG

prospective payment system will be as follows:

a. A hospital which transfers a patient will be paid a per diem rate for the appropriate DRG in accordance with Section V of this plan. The per diem rate for claims being paid per discharge is determined by dividing the hospital's total DRG payment rate as described in Section V by the average length of stay for that DRG.

b. A hospital which receives a transfer patient and subsequently discharges the patient will be paid the full payment for the appropriate DRG in accordance with Section V.

4. Any hospital involved in the transfer of an individual, either as the transferring or as the receiving hospital, may also qualify for outlier payments as described in A of this section.

D. Payment for Readmission

1. Readmissions to the same or any other facility within 15 days of discharge for the same spell of illness and for the same DRG or general diagnosis as the original admission may be considered after review to be part of the same admission. If two claims are submitted, they may be merged after review and one payment may be made to the facility of the readmission. Payment to the facility of the first admission may be modified or denied if it is determined that the first admission involved a premature discharge which resulted in the readmission. This applies to both per diem and per discharge cases.

2. Readmission to the same or another facility within 30 days of a previous discharge for the same DRG or a similar diagnosis shall be subject to utilization review. The Commission may deny or recover full or partial payment for the original stay or the subsequent readmission if it is determined that the original facility should have provided all required services during the original inpatient stay.

3. This section will not apply in cases where a patient leaves the hospital against medical advice.

E. Payment for Same-Day Discharges

Special payment provisions will apply for patients discharged on the same day they are admitted. In these cases the hospital will be paid one-half of the appropriate DRG day. This amount will be determined by multiplying the applicable DRG relative weight by the hospital discharge rate and dividing by twice the average length of stay for the DRG. However, when a patient is admitted and discharged, and subsequently readmitted on the same day, the hospital will be paid only one per discharge or per diem payment as appropriate.

F. Payment for Swing Bed Days

Acute care facilities will be reimbursed for qualifying skilled and intermediate care Medicaid patients in accordance with the daily rate schedule shown below.

October 1, 1992 - September 30, 1993	$62.67
October 1, 1993 - September 30, 1994	67.22
October 1, 1994 - September 30, 1995	70.36
October 1, 1995 - September 30, 1996	75.84
October 1, 1996 - September 30, 1997	79.01
October 1, 1997 - September 30, 1998	83.38
October 1, 1998 - September 30, 1999	86.69
October 1, 1999 -	92.64

This rate calculation is described in the Nursing Home State Plan Attachment 4.19 D, page 28, paragraph H.

G. Payment for Administrative Days

Acute care facilities will be reimbursed for Medicaid eligible skilled or intermediate patients who no longer require acute care and are waiting for nursing home placement. Administrative days must follow an acute inpatient hospital stay and will be covered in any hospital as long as a nursing home bed is not available. Reimbursement for administrative days is described below.

1. Each administrative day will be paid in accordance with the rate schedule shown below. This daily rate will be considered payment in full. There will be no cost settlement. This rate is a combination of the swing bed rate, as defined above, plus the Alternative Reimbursement Method (ARM) rate for pharmaceutical services.

October 1, 1994 - September 30, 1995	$73.98 (ARM $3.62)
October 1, 1995 - September 30, 1996	79.68 (ARM 3.84)
October 1, 1996 - September 30, 1997	83.23 (ARM 4.22)
October 1, 1997 - September 30, 1998	88.02 (ARM 4.64)
October 1, 1998 - September 30, 1999	91.79 (ARM 5.10)
October 1, 1999 -	98.21 (ARM 5.57)

2. A rate of $180.00 per day will be available for administrative day patients who require more intensive technical services (i.e. patients who have extreme medical conditions which require total dependence on a life support system). This rate was determined by cost analysis of:

   a. A small rural S. C. hospital which was targeted to set up a ward to provide services for this level of care and

   b. An out-of-state provider which has established a wing in a nursing facility to deliver this type of service.

   This per diem rate will represent payment in full and will not

be cost settled.

H. Payment for One Day Stay

Reimbursement for one day stays which group to per discharge DRGs (except deaths, false labor, normal deliveries (DRG 373) and normal newborns (DRG 391)) will be reimbursed a DRG per diem. A DRG per diem is equal to reimbursement for applicable DRG divided by the average length of stay for that DRG.

I. New Facilities

1. Prospective payment rates for facilities with finally-settled base year cost reports which do not reflect 12 full months of operation or were not in operation during the base year will be determined as follows:

   a. For hospitals under the Hybrid system, payment will be at the statewide average for the appropriate DRG plus a percentage add-on for projected capital and medical education costs plus outlier payments as applicable.

   b. For freestanding long-term care psychiatric facilities, payment will be at the statewide average per diem for long term care psychiatric facilities plus projected capital and medical education costs as applicable.

   c. For Residential Treatment Facilities, payments will be based on a statewide average of all the RTF rates.

2. A new facility will submit its projected capital and medical education cost to the DHHS on the forms and in the format prescribed by the DHHS.

3. The rate for a new facility will apply until recalculation of the base year.

4. A new facility will not qualify for disproportionate share payments until the appropriate hospital fiscal year information is available.

J. Out-of-State Facilities

Payments to out-of-state facilities will be paid according to one of the following methods.

1. Contracting facilities in border states which submitted completed South Carolina specific Medicaid cost reports for the base year and other required documentation will be paid in accordance with in-state facility procedures.

2. When a rate has been set for a provider during a PPS rate period and the provider decides not to contract with the South Carolina Medicaid Program (SCMP) at anytime during that period, the facility

will receive the set rate (with inflation applied if applicable).

3. Any provider approved to contract with the SCMP for which a facility-specific rate has not been calculated, will receive the statewide average rate. Facility-specific add-ons for Direct Medical Education, Indirect Medical Education and Capital may be calculated with the submission of information requested by the DHHS. The facility must send a written request in order for the DHHS to consider facility specific add-ons.

K. New Medicaid Providers

Prospective payment rates for established facilities which did not submit a South Carolina hospital-specific Medicaid cost report for the base year because the facility did not participate in the South Carolina Medicaid program at that time, will be determined as stated in I 1 a, b and c of this section.

L. Small Hospital Access Payments

Effective October 1, 1999, small hospital access payment adjustments will be paid to eligible hospitals in 4 quarterly installments throughout the year. In order to be eligible for this payment a hospital must meet the criteria defined in Section II 32 of this plan. The payment amount is equal to 13.5% of each qualifying hospital's total 1997 Medicaid revenue and will be allocated between inpatient and outpatient services.

M. High Volume Adjuster Payments

Effective October 1, 1999, high volume Medicaid adjuster payments will be paid to eligible hospitals in 3 installments throughout the year. In order to be eligible for this payment a hospital must meet the criteria defined in Section II 13 of this plan. Qualifying hospitals will be eligible to receive a payment from the high volume Medicaid adjuster fund.

(Deemed Approved)

SC: MA 99-007
EFFECTIVE DATE: 10/01/99
RO APPROVAL: AUG 2
SUPERSEDES: MA 98-011

VII. Disproportionate Share

A. Payments

Disproportionate share hospital (DSH) payments shall be made in accordance with the requirements of Section 1923 of the Social Security Act and the South Carolina state legislature. DSH payments will be paid to those facilities meeting the requirements specified in Section II 11.

1. Effective October 1, 1999, DSH payments will be set as follows:

   a. Public hospital DSH payments will be equal to each hospital's inflated upper payment limit adjusted by the new Medicaid revenue paid to hospitals. New Medicaid revenue includes rate increases, high volume adjuster payments and small hospital access payments.

   b. Non-public hospital DSH payments will be equal to 90% of each hospital's inflated upper payment limit adjusted by the new Medicaid revenue paid to hospitals. New Medicaid revenue includes rate increases, high volume adjuster payments and small hospital access payments.

   c. SC Department of Mental Health (SCDMH) hospital DSH payments will be equal to each hospital's inflated upper payment limit for SC uninsured patients.

2. Effective October 1, 1999, each hospital's upper payment limit reflects their inflated fiscal year 1997 unreimbursed Medicaid and uninsured SC patient cost with the exception of SCDMH hospitals (see 1 c above). Additionally, the cost limit of DSH hospitals designated as Level I trauma centers will include the unreimbursed extraordinary costs for the following services related to Level I centers: emergency room physicians, intensivists, CRNAs and ambulance. Inflated fiscal year 1998 unreimbursed costs for these trauma services for SC Medicaid and SC uninsured patients will be included in the DSH upper payment limit.

3. The following HCFA Market Basket indices will be applied to the hospitals' fiscal year 1997 base cost.

Calendar year (CY) 1997	2.1%
CY 1998	2.7%
CY 1999	2.5%

Inflation will be applied using the midpoint to midpoint inflation method. DSH payments are paid during the SC state fiscal year (SFY), therefore, inflation will be applied through December 31st, the midpoint of the SFY (July 1st through June 30th).

4. All disproportionate share payments will be made by adjustments during the applicable time period.

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B. Additional Requirements

All qualifying providers (hospitals) must adhere to the following rules as set forth in the memorandum of agreement between all participating hospitals and the South Carolina Medicaid Program.

1. The Provider's board chairman and either chief executive officer or chief financial officer shall meet with the DHHS's staff to ensure understanding of the DSH program;

2. The Provider agrees to participate in a peer review system to perform reviews of data resulting in DSH eligibility. Peer review and certification by the peer review group to the DHHS that the data is reasonable may be a prerequisite to a hospital receiving a DSH payment based on the data. Any dispute about the validity of the data must be resolved between the affected hospital, the peer review group and the DHHS;

3. The DHHS will escrow funds and make DSH payments to those hospitals deemed eligible by DHHS. The State Auditor's Office (SAO) may be asked to perform a comparison of data based on agreed-upon procedures subsequent to payment;

4. The Provider agrees to be responsible for supplying acceptable documentation to substantiate the allowable unreimbursed costs in the event of a HCFA audit. If the audit results in a payback, the Provider is responsible for the payback amount. This will apply to DSH payment disallowances for payments made on or after October 1, 1999;

5. All payments are prospective. Only recoupments resulting from negative adjustments to data will be allowed.

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